Payment Policy:Clean Claims

Reference Number: LA.PP.021
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 06/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The purpose of this policy is to define the minimum claim submission requirements for claims submitted to the health plan for processing from all providers, including facilities (e.g., hospitals, ambulatory surgery centers) and professional providers (e.g., physicians, independent therapists).

Application
This policy applies to all claims received by Louisiana Healthcare Connections submitted by facilities and individual providers for review, adjudication, and processing.

Policy Description
Consistent with Federal and State law and contractual obligations, the health plan is responsible for timely adjudicating a claim only when it is a "Clean Claim."

Clean Claim
A Clean Claim is defined as a claim received by Louisiana Healthcare Connections for adjudication that has been completed and submitted without technical defect in its form, completion, or content. In order to constitute a Clean Claim, the claim must necessarily: a) comply with all standard coding guidelines; b) contain no missing information; and c) be free of any potential defect or impropriety due to unbundling, incorrect or obsolete coding, or medical necessity. Further, a Clean Claim must include all substantiating documentation that the health plan deems necessary for its adjudication, and not require special processing or consideration, which would otherwise delay or prevent timely payment of the claim. In addition, the following types of claims shall not constitute a Clean Claim: (a) a claim for which fraud is detected or suspected; and (b) a claim for which a third-party payer may be responsible.

Clean claim requirements are consistent with specific guidelines of the State. The State legislature stipulates minimum requirements, but also may allow the health plan to modify, add, or remove clean-claim elements as outlined by the State, including attachments, to allow the health plan to specify processing procedures for submitting claims.

Prompt-payment timeframes are measured from the clean date of the claim. The clean date is the date when the requested information required for resolving the suspended line(s) is received, and the claims processing system of record is updated by removing the "non-clean" EX code to populate the clean date.

A claim will not be considered clean unless it contains all information provided in "Claim Form Field Requirements" listed in the State billing manual for paper claims and all information according to the state specific companion guide for claims submitted via a HIPAA compliant

837I and 837P electronic claim. Claims for acute inpatient and other inpatient and outpatient facilities are to be submitted on the UB 04 or 837I, and claims for individual professional items and services are to be submitted on the CMS 1500, 837P, or through direct data entry via the Web.

Non-clean Claim
A Non-clean Claim is a claim submitted to Louisiana Healthcare Connections that requires further investigation or development beyond the information contained on the claim submitted for adjudication. The errors or omissions on the claim may result in: a) a request for additional information from the provider or other external sources to resolve or correct data omissions or billing errors on the claim; b) the need for review of additional medical records; or c) the need for other information necessary to resolve plan benefit limitation issues and/or other discrepancies. In addition, a Non-clean Claim may require review for medical necessity or may not have been submitted within the applicable filing deadline.

Reimbursement
Upon receipt of a claim, the health plan will commence processing and will determine whether the claim constitutes a Clean Claim. The health plan will notify providers through a HIPAA-compliant electronic 835, or 997 remittance-advice transaction or in writing via an Explanation of Payment (EOP) when claims are submitted that do not meet the criteria defining a Clean Claim. The health plan will advise the provider what additional information is necessary for the health plan to continue to adjudicate the claim. Once the health plan receives the additional requested information, it will resume adjudication of the claim and will, as appropriate, advise the provider if additional information is necessary to complete processing of the claim, causing the claim to remain a Non-clean Claim. Upon the health plan notification to a facility that a claim constitutes a non-Clean Claim, the claim processing timeframe will be suspended and will not resume until the health plan receives the information requested in the Non-clean Claim notification, and determines that the claim may then be processed as a Clean Claim.

Utilization
Providers consistently submitting Non-clean Claims may be contacted for provider education.

Documentation Requirements
Claims must be HIPAA compliant and submitted electronically or by using CMS 1450 (UB 04) or CMS 1500 claim forms, as appropriate for the provider type making the claim.

Before a claim can be processed, it must be a “clean” (i.e., complete) claim submission, and must contain all required information and meet the conditions below:

- Primary carrier Explanation of Benefits (EOB), when Louisiana Healthcare Connections is the secondary payer;
- Standard ICD-9-CM/ICD-10-CM, ICD-10-PCS, CPT, HCPCS, and revenue codes, as appropriate;
- Does not require additional development for adjudication on its merits (i.e., requires no investigation or requires investigation by the Claims, Medical Review, or Payment

departments, but without the need to contact the provider, the member, other payer, or other outside source under the paper requirements or companion guide);
- Claims subject to medical review must contain complete and pertinent medical records that have been attached by the provider or forwarded in accordance with the health plan's instructions; and
- Has all basic information and supporting documentation the health plan determines is needed to adjudicate the claim resulting in a paid or denied status.

Louisiana Healthcare Connections will remit claims that do not meet the minimum requirements as either a 997 rejection, rejection letter, or a denied remittance code (EX code), with the denied reason on either the rejection notice or the remittance code.

For more information on State claims processing procedures, refer to the State billing manual to validate the claim-form requirements.

Additional Information
Except as noted, Louisiana Healthcare Connections may require clinical documentation at the time a claim is submitted for the following categories of claims to be considered complete:
- Codes appended with a modifier indicating additional or unusual services (e.g., 22, 23, 53, or 66);
    - Exception: The following modifiers do not require clinical records:
        - Any HCPCS Level II modifiers;
        - CPT modifiers 24, 25, 26, 52, 59, 63, or 90;
- Codes to which an assistant or co-surgeon modifier is attached that do not normally require assistant or co-surgeons;
- Any code listed in the "Unlisted Services and Procedures" section of the CPT Manual Index.
- A diagnosis code defined as "not otherwise specified" (NOS);
- A diagnosis code defined as "not elsewhere classified" (NEC);
- Procedures that are potentially cosmetic;
- Pharmaceuticals (including, but not limited to, pharmaceuticals used outside of the scope of their FDA-approved uses) and procedures that may be experimental or investigational;
- Procedures that are medically necessary for some indications and not for others; and
- Services performed in an unexpected place of service, such as office services performed in an outpatient surgery center.

In addition, the health plan may require submission of clinical records before or after payment of a claim for the purpose of investigating potentially fraudulent, wasteful, abusive, or other inappropriate billing practices, but only as long as the health plan determines it has reasonable basis for believing such investigation is warranted.

Types of clinical documentation that may be requested include:
- Emergency Department records
- Facility records
- Anesthesia notes with times
- Operative summaries

- Radiology interpretation and reports
- Laboratory results
- Physician and/or non-physician practitioner office notes
- Any other pertinent medical records

Related Documents or Resources
Please consult the applicable State Medicaid billing manual for additional information.

References
1. *Current Procedural Terminology (CPT®)*, 2022

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	8/20	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/22	
Annual Review; updated reference date.	6/23	9/13/2023

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to an actual signature on paper.